R E P O R T R E S U M E S

ED 018 330 RE 001 167

A LANGUAGE TRAINING PROGRAM IN A CHILD GUIDANCE CENTER.

BY- BAIN, MARY D. AND OTHERS

PUB DATE FEB 68

EDRS PRICE MF-$0.25 HC-$0.64 14P.

DESCRIPTORS- *REMEDIAL PROGRAMS, *EDUCATIONAL THERAPY, *LEARNING DIFFICULTIES, *PERCEPTUALLY HANDICAPPED, *PSYCHOEDUCATIONAL CLINICS, LANGUAGE PROGRAMS, REMEDIAL TEACHERS, PERCEPTUAL DEVELOPMENT, PSYCHOLOGICAL SERVICES, GUIDANCE SERVICES, GUIDANCE CENTERS, GREATER LAWRENCE GUIDANCE CENTER, LAWRENCE, MASSACHUSETTS,

FOUR ARTICLES DEALING WITH THE ROLE OF THE GREATER LAWRENCE GUIDANCE CENTER LANGUAGE TRAINING PROGRAM IN HELPING CHILDREN WITH LEARNING DIFFICULTIES ARE PRESENTED. THE FIRST PAPER EXPLAINS HOW THE CENTER SOLVED THE PROBLEM OF OBTAINING MORE ACCURATE AND COMPLETE DEVELOPMENTAL HISTORIES OF REFERRALS BY GIVING MORE ATTENTION TO PERCEPTUAL-MOTOR DEVELOPMENT. THE SECOND PAPER EXAMINES HOW THE CLINICAL PSYCHOLOGIST HELPS DIAGNOSE LEARNING PROBLEMS, INTERVIEWS PARENTS, TAKES DETAILED DEVELOPMENTAL HISTORIES, AND GIVES PSYCHOLOGICAL TESTS BEFORE A CHILD IS REFERRED TO THE SPECIAL THERAPEUTIC EDUCATIONAL DEPARTMENT. THE THIRD PAPER DWELLS ON THE LANGUAGE TRAINING PROGRAM LAUNCHED BY THE CENTER. THE FOURTH PAPER DESCRIBES THE TASKS THE LANGUAGE TRAINING CONSULTANT PERFORMS-- STUDYING THE PERSONALITY AND BACKGROUND OF VOLUNTEERS, GIVING THEM INTENSIVE TRAINING, AND SUPERVISING THEIR WORK WITH CHILDREN. THESE PAPERS WERE PRESENTED AT THE ASSOCIATION FOR CHILDREN WITH LEARNING DISABILITIES CONFERENCE (BOSTON, FEBRUARY 1968). (NS)

GREATER LAWRENCE GUIDANCE CENTER

217 Haverhill Street
Lawrence, Massachusetts 01840

A LANGUAGE TRAINING PROGRAM IN A CHILD GUIDANCE CENTER

Panel Participants

Mary D. Bain, M.D.
Psychiatric Director

John M. Harmes, M.A.
Chief, Psychology Department

Anne U. Vargus, ACSW
Coordinator, Special Therapeutic Educational Services

Reta V. Buchan
Language Training Consultant

Presented at Massachusetts ACLD Fifth International Conference -
February 1968 - Boston, Massachusetts

THE CLINIC FACES THE PROBLEM . . . . . Mary D. Bain, M. D.

The Greater Lawrence Guidance Center is a state and community supported mental health center in northeastern Massachusetts, serving a population of about 130,000. The children's service, an outpatient psychiatric service, is approved by the American Association of Psychiatric Clinics for Children. Our patient population as in most child guidance clinics, includes a large percentage of children referred because of school failure.

As a child psychiatrist, I have long been concerned with the over-zealous and exclusive use of analytic concepts to explain all the vicissitudes of children's learning patterns and to stereotype parent-child relationships. A clinician is, of necessity, a scientific observer and, as such, must keep an open mind, must make accurate observations and must refrain from too rapid cause-effect conclusions.

Before appropriate therapeutic recommendations can be made, we must have sound diagnostic formulations.

Early in his training, a physician is taught that a sound diagnosis depends upon a careful history as well as a careful examination of the patient, and that later other special examinations may be indicated. For reasons not entirely clear to me, in the clinic practice of psychiatry and particularly child psychiatry, the taking of the patient's medical history has been delegated to the social worker. As might be expected, this has resulted in quite complete appraisals of the child's environment including details of family interaction, but little attention paid to the medical history or to a precise record of physical, particularly perceptual development.

In an effort to remedy this situation, as our clinic "faced the problem", we carried out informal in-service training for all staff members, regardless of discipline, who were responsible for obtaining of histories. At present, our psychiatric nurse and our chief social worker are developing a check list schedule which hopefully will help in providing more complete and perhaps more uniform recording.

About eight or nine years ago, we began to take a second look at our patients with learning problems, particularly those patients who seemed better adjusted after prolonged psychotherapy but who still had difficulty with spelling or writing.

For example, this notation was written by a child psychiatrist following a year of psychotherapy with an eleven year old child of very superior endowment:

> Patient was seen in weekly appointments for the past year. Treatment is being terminated because the family is moving back to the West coast. Attendance at treatment sessions was regular except for a few instances of illness. Clinical improvement was only relatively satisfactory during this period. Patient showed increasing ability to express his aggressive feelings and seemed more at ease in his relationship to his father. Although his reading improved somewhat during therapy, his handwriting remained almost entirely illegible.

When we re-examined the child's record, we found the following facts on the developmental history: patient walked early, at nine months; speech was slow, over two years with articulation difficulties for which he had received speech therapy. Patient had been referred because of school failure. Our diagnosis: "Learning problem on an emotional basis," and our recommendation, of course, was for psychotherapy.

There was a family problem in this case and the child was reacting to parental conflict. In retrospect, it is possible that this inaccurate appraisal might have actually worsened the parental problem since, in addition to their own interpersonal conflict, the parents felt, and this feeling was not dispelled, entirely responsible for the boy's severe language disability. It is further possible that the inaccurate appraisal might have over-emphasized the parental problem in the child's therapy and certainly delayed his receiving the appropriate and much needed tutorial help. It is clear to us now that this patient had a severe perceptual motor disability.

A pattern of uneven development is found over and over in the histories of children referred with learning problems, for example, early walking (9-10 months), late talking (over 2 years), hyperactivity (often described by parents as exhausting and different from siblings), difficulty in mastering fine motor tasks (for example, tying shoelaces), and very often speech disturbances (for example, articulation difficulties, prolonged or transitory stuttering or lisping). In addition, some of the histories may describe a difficult birth or prematurity; some may reveal a family history with generations of similar learning difficulties.

Clearly then, a second look was mandatory. More complete medical histories must be taken and more attention given to the child's perceptual and motor development. Perception is the process by which the brain arranges and interprets the many

stimuli that impinge upon the sensory organs. To simplify: vision is not solely the accomplishment of the eyes -- "the eyes see, the brain learns." In like manner, "the ears hear -- the brain recognizes the sound."

A disturbance in the areas of the brain which function in perception is likely to produce distortions over the whole range of human sensory experience. Sight, hearing, taste, touch and kinesthetic data may be affected. Mechanically, the sensory organs may be perfect, the handicap resides in the reduced ability of the brain to use the data.

As we became more aware that perceptual disabilities might be the primary cause in many learning disturbances, these questions were posed by our clinic staff:

1. How many children have this problem and what remedial educational facilities are available to them in our community?
2. If we could detect the problem earlier, could we prevent the secondary psychiatric symptoms of frustration, lack of motivation, anxiety, poor self image, and even school drop-outs, and
3. What can be done for those children already our patients?

To answer these questions and to describe our language training program, we will hear from our panel members.

ROLE OF THE CLINICAL PSYCHOLOGIST . . . . . John M. Harmes, M.A.

The psychologist must be a specialist in learning problems. Approximately 25% - 35% of the total number of new patients coming into the children's service of this clinic have school failure as the predominant symptom. Between 50% and 60% of the patients referred to the clinic's psychology department are children with learning problems.

As a specialist in the diagnosis of learning problems, the psychologist considers the following hypotheses:

1) the link between the family secret and the inability to "know";
2) the success-failure complex in the child unable to please both parents;
3) the derogation of the child, or of learning itself;
4) excessive passivity as a defense;

5) the identification of the child with a relative considered to be a failure;

6) the importance of prolonged anxiety which drains the child's energy from the learning process;

7) the effect of physical handicap which limits the child's psychological growth through narrowing of his experiential field;

8) the effect of maternal deprivation which often accompanies a depression of the mother resulting in curtailed nurturing;

9) cultural deprivation.

In analyzing diagnostic data of a large number of patients with learning problems, we found the above formulations in many cases irrelevant and when they seemed relevant, they were incomplete.

Although family pathology may contribute to a child's learning problem, it cannot be viewed as the cause of perceptual handicap. In interviewing parents as part of the diagnostic process, the psychologist found in many instances, clinically adequate parents, who, in his opinion, could not have caused consciously or unconsciously the learning problem of the child. As careful and detailed developmental histories were taken, it was found that a significant number of these children had an uneven early development, for example, early walking, late language development frequently accompanied by speech defects and motor development characterized by awkwardness and stumbling.

The following report of a consultation session to a school illustrates the rapidity with which secondary emotional symptoms appear in a child with perceptual problems and highlights the lack of preventive thinking in the tentative regulations referable to the Commonwealth's current legislation for education of children with perceptual problems. These regulations state that a child must be two or more years retarded in one or more basic subject even before being eligible for screening.

> Miss Jones, a principal of a school in our area, told us about Robert, a child who later entered her school. Robert had been enthusiastic about the prospect of starting school; he had been given the usual pencil box by his parents prior to opening day. He had frequently talked with Miss Jones enthusiasticly about going to school. She described Bob as outgoing, attractive, enthusiastic, well behaved, and an unusually bright child.

> Six weeks after school started, Miss Jones looked in to see how her friend was doing. She found a sad, depressed youngster and was concerned. In checking with his teacher, and in watching him at his beginning tasks, she found that he held his pencil awkwardly and was totally unable to copy any of the letters of the alphabet.
>
> Miss Jones, having attended the teachers' seminar at the Guidance Center, was alerted to the problem of the perceptually handicapped child, and was quick to refer parents to the clinic to confirm the diagnosis and to start a remedial program.

The teachers' seminar, referred to above, was a seminar on Learning Problems and included a description of perceptual handicap. It became apparent that many of the teachers had students with characteristics of this problem. They referred many of these children to the clinic for study. As time went on, the presenting problem was apt to be, "this boy writes clumsily and sometimes backwards", or, "this girl with Pintner-Cunningham I.Q. 125, with an A in arithmetic, can't spell".

When a child is referred to the psychology department for evaluation, a detailed developmental history is obtained with an assessment of the reliability of the informants. The child's size, gait, fine and gross motor coordination and speech are noted. In regard to the child's test behavior careful attention is paid to restlessness, hyperactivity, or attention and concentration difficulties.

It is easier to diagnose a perceptual motor disturbance in young children than in the adolescent where extensive secondary emotional symptomatology has developed. The clinical battery consists of the WISC, Bender-Gestalt, Metropolitan Achievement Tests, spelling and arithmetic sections, Gilmore Oral Reading, Borea-Gestalt, and Sentence Completion. A sample of the child's handwriting is obtained. There is a wealth of perceptual motor information in the raw data of the school's testing program, (e.g., subtest 6, Copying, and subtest 4, Matching of the Metropolitan Readiness Test.)

On the WISC there are difficulties on coding subtests because of problems in automatization which "refers to the ability to perform simple, repetitive tasks rapidly and accurately". On the Bender-Gestalt, the following are diagnostically significant and indicative of perceptual motor porblems: poor organizations, distortions, rotations, reversals, difficulty with the horizontal plane, perseveration and difficulty with the inner detail.

On the Reading Achievement Test, difficulties with prepositions, pronouns, reversals of words and letters within a word, tendency to skip lines, and labored reading are significant. On Spelling Tests there is difficulty in perceiving letters and words, resulting not only in reversals but also in bizarre reproductions. Writing may be shaky, irregular, or poorly coordinated.

Arithmetic achievement may not be affected but when there is a problem it takes the form of the difficulty already described, namely, reversal of numbers.

The Sentence Completion test gives insights into the child's feelings about learning, self-image, and his perceptual problem. Although more extensive testing might be done with a more refined battery such as the Illinois Test of Psycholinguistic Ability, a more extensive reading test and perhaps portions of the Frostig, the above battery has been sufficient for our purposes.

After a diagnosis is made, the child is referred to our Special Therapeutic Educational Department for appropriate help.

THE DEVELOPMENT OF THE LANGUAGE PROGRAM . . . . . Anne U. Vargus, ACSW

You have heard Dr. Bain and Mr. Harmes describe the evolution and transition of our diagnostic thinking related to learning problems. With this crystallization of a more precise differential diagnosis, efforts were made to interpret our thinking into the professional and lay community of Greater Lawrence. This process resulted in a marked increase in the number of children with Perceptual Difficulty being referred to the Guidance Center. Where previously it was most common for parents to request help for their children with a chief complaint of behavior or school problem, teachers and parents now were referring with the chief complaint, "I think Johnny has dyslexia". In a very short time, we found ourselves with long lists of children diagnosed at the Clinic as Learning Disturbance involving Perceptual Difficulty; and with no resources, either public or private, in the Greater Lawrence community, to provide the appropriate remedial education for these youngsters.

This lack of resources posed a serious dilemma for the clinic. Aware that a child with perceptual difficulty experiences frustration and school failure, that the constant impact of this results in a lowering self-image and secondary emotional

disorders, we, as clinicians, were concerned about the prevention of these psychiatric symptoms. It was our conviction that appropriate preventive and therapeutic intervention for this multi-faceted but treatable disability must reach several levels simultaneously. Within this framework, we began to alert schools, parents, and community to the nature of this problem. In view of the resource vacuum, we addressed ourselves to the appropriate role of the clinic vis a vis the children already clinic patients.

We consulted with Mrs. Buchan about the possibility of formalizing a tutor-training program at the Clinic to provide these remedial services. In November 1964, the Clinic employed Mrs. Buchan, as a consultant, to formalize the training program and supervise the trainees. We began with five volunteers, residents of Greater Lawrence, who were carefully screened through the Volunteer Department. Today, three and a half years later, we have trained fifteen volunteer tutors who have provided language training for approximately fifty children. These volunteer tutors contracted with the Guidance Center to give a minimum of four hours per week for training instruction and the supervised tutoring of at least two children.

Many children with perceptual difficulty are slow in learning to talk, often find it difficult to express themselves orally, and/or frequently lisp or stutter. Our program was enhanced when a trained and experienced Speech Therapist volunteered and enrolled in the training program. Her background was most valuable, for in addition to tutoring, she was able to provide speech therapy where prescribed.

In 1966, we added one full-time Commonwealth Service Corps volunteer to our language training program. This particular volunteer, a graduate of the New England Conservatory of Music, is an experienced instructor of music. After eight weeks of the initial training instruction, study, and program experimentation with consultation and supervision, she developed a rhythmical motor program for small groups of young children. The development of this particular segment of the program was possible through the assimilation of her background in music with the knowledge and methods of language training. With the combination of these specialties, she designed a method of using a wide range of gross motor activities and rhythmic handwriting exercises to develop the visual, auditory, and kinesthetic linkage in these youngsters. For the preschooler with this syndrome, this program has been especially helpful in that it starts the child on the road to improving perceptual skills, thereby helping

to minimize the difficulties he would have otherwise experienced when he entered school. From a preventive standpoint, it is felt that the earlier the diagnosis and instruction, the more successful the outcome.

Our basic aim has been to provide a tutorial program designed to meet the specific needs of the children. Most of the children are seen for individual instruction; others are seen in small groups, then assigned to more intensive individual tutoring. Some children, because of immature behavioral patterns, evidenced by short attention span and excessive hyperactivity, are seen individually first, then are assigned to small groups as their behavioral patterns improve. The tutors submit quarterly reports describing progress or problems with the child patients. These reports are reviewed by the child psychiatrist who may or may not suggest an alteration of the tutorial approaches.

The length, frequency, and intensity of tutoring varies according to the age and intelligence of the child, as well as the severity of the disability. Children who manifest severe secondary psychiatric symptoms, often a result of years of failure which has produced deeply internalized, well-justified discouragement, may be seen for psychotherapy either before instruction or concommitantly, depending on the advice of the clinical team. It has been our experience that relatively few children require psychotherapy in addition to tutoring. More often, the support of the tutor who approaches the child with warmth and knowledge of his problem, provides sufficient emotional support needed to correct the loss of self-confidence and the lowered self-image.

During the past three and a half years, the clinic's language training program has provided a service in our community where previously there had been none. We are cognizant that this program is a stop-gap measure. The ideal program should be tracked through the school system, provided daily and intensively. Towards this goal, members of this panel have met regularly in the past few years with local school officials. At these meetings we discussed our increasing awareness of the numbers of children in the Greater Lawrence community with Perceptual Disability. We described our program, its philosophical basis, justification and realistic limitations. These meetings provided an atmosphere for frank discussion, and exchange of ideas and knowledge. It became clear that the im-

plementation of direly needed remedial programs could not be initiated quickly or easily.

On September 3, 1966, the Commonwealth of Massachusetts passed legislation providing for the instruction and training of children with certain learning impairments, with reimbursement to the city, town and school district, thus our effort with local educators was not only timely, but relevant. As the individual school systems began to develop their programs, clinical staff members consulted with them regarding screening procedures. During the past year, two of the communities have begun to implement not only screening procedures, but instructional classes for their teachers and retraining programs for their students. The remaining school systems are making concerted efforts in this direction.

Simultaneous with our direct efforts with school administrators, Mr. Harmes conducted a Seminar on Learning Problems for teachers in our community. This seminar was another avenue for communication. It provided teachers with more detailed information about learning problems and enabled them to understand better the students' behavior in a regular classroom. This encouraged them to devise creative methods for the teaching of these children in the school setting. Here our psychologist made a real contribution to the teachers by providing knowledge, support, and interpretation.

As we broadened our diagnostic formulations regarding learning problems, we found it necessary to readjust our clinical approach with parents. Initially parents were assigned to the Social Service Department for casework treatment. It became clear that this was an inappropriate use of the casework method. Parents of children with Perceptual Difficulties found little relevance between a discussion of their marital adjustment and intra-family tensions and a need for their children to have a specific kind of tutoring. As we became more sophisticated in our thinking, we further refined our methods, gathering most of our clues from the comments of parents. We moved from casework treatment with parents to group education led by a social worker. At intervals, various staff members and the volunteer tutors were called upon to meet with the parents.

We are aware that in some instances the behavioral symptoms strain the relationships of these children in their environment with the result that they are often singled out as a source of disruption of family tranquility. We are aware

that the reaction of parents and siblings may set in motion a chain of events which may further impair the child's functioning. This lack of approval may generate hostility in the child, therby reenforcing patterns of rejection, and lowering self-esteem even further. Unhealthy patterns of behavior, reenforced over long periods of time combined with unrealistic environmental expectations, can contribute to a concretizing of secondary psychiatric symptoms. From the standpoint of prevention, we felt that it was most important to intervene as early as possible and interupt this cycle of reinforcement. With a deeper and more realistic view of the problem, parents are freer to give much needed support to their children. In our experience, this opportunity for frank discussion was corrective and reassuring.

Although the main emphasis of the group was the education of parents in regard to the nature of Perceptual Difficulty, copies of recent legislation were distributed encouraging parents to support school interest in the development of appropriate educational programs. Thus, the group method served not only to inform not only to relieve unnecessary parental guilt, but promoted an opportunity for effective social action.

Paralleling our efforts, was the formalization of a local Chapter of the Association for Children with Learning Difficulty. This organization called upon clinic staff to attend their meetings, not only to describe our program but to enhance their overall knowledge of perceptual disability.

The impact of the clinic program described, the recent legislation, the organization of a local Chapter of ACLD, the increasing frequency of written material for lay and professional groups, has moved the Greater Lawrence community from a pioneering and preventive program effort toward a more sophisticated recognition of the importance of the early detection of difficulty in the acquisition of perceptual skills.

In our experience with this program, clinical observation suggests sufficient improvement and success to merit a more formalized research effort. We are hopeful that a more scientific evaluation can be effected within the next year.

With this description of the development of our language program as a frame of reference, Mrs. Buchan will now speak to you on the Role of the Language Training Consultant.

THE ROLE OF THE LANGUAGE TRAINING CONSULTANT . . . . . Reta V. Buchan

A proposal such as that presented by the Greater Lawrence Guidance Center was a challenge of no mean proportions. Time, space, and money available were all limited indeed, yet there was a demonstrated need for service and it was clear that this would be a plowing of new soil, a sort of pioneering venture.

Volunteer trainees, recruited by the Volunteer Department at the Guidance Center, had already conveyed their interest in the program, their availability as to days and hours, and their motivation.

The first task of the consultant was to conduct a final screening interview with each of the volunteers recruited.

It is appropriate to explore the applicant's educational background and experience with children. All of those accepted for the program have had some study beyond the secondary level; most have completed a bachelor's degree program; some have completed study at the master's level. Several have had teacher-training and teaching experience. Without exception, all selected trainees have had experience in working with children -- in a family situation and/or in organized groups.

In exploring their motivation in volunteering for this program -- a significant factor in the control of mortality rate -- it was found that some had known and dealt with children with reading and language problems and all were responsibly committed to being of service to children.

Most important of all was an evaluation of the candidate as a person: her probable flexibility in a teaching-learning situation, her creativity in planning her work, her ingenuity in developing materials, her patience and empathy, her warmth and sparkle as a relating person.

The training begins with a series of intensive instructional sessions conducted weekly over a period of three or four months. Outside reading and other assignments are an integral part of this plan.

When the tutoring assignments are made, clinic staff members meet with the trainees to discuss relevant diagnostic material. Throughout the year, the consultant continues to make these findings meaningful to the trainees. Typically, each trainee is assigned two children for weekly instruction; these sessions are always held at the clinic. The appointments are scheduled for the same day as the training

class, making it possible for the consultant to deal with problems as they arise -- through direct supervision, individual instruction, and group discussion. Supervision and consultation continue weekly for three years. In the fourth year, consultation is provided monthly.

Each trainee is required to keep a detailed log, organized on a careful plan, and at three-month intervals submits a progress report on each case. Duplicate reports are filed in the child's cumulative record as well as in his medical record at the Center.

Since the time for the program is necessarily limited, the educational operation must be carefully designed. Primary focus is made upon the decoding process basic to a language program, as it is felt to be especially significant in a remediation program for children with specific language disabilities. Additional supportive help is provided in small groups for some of the younger children showing perceptual-motor handicaps, using rhythmic activities.

Trainees are first given an initial exposure to the basic philosophy of an alphabetic-phonetic approach to language learning. They are encouraged to explore, as widely as possible, the literature on language disabilities and the available teaching materials.

The course includes:

1) A detailed exploration of the sound-symbol relationships of English, proceeding from the more constant to the more variable.
2) A presentation of the linguistic patterns useful and understandable at each academic level.
3) Study of the visual, auditory and tactile-kinesthetic channels to language learning, with some attention given to ways of capitalizing on strengths and correcting weaknesses evidenced by the children.
4) A necessarily superficial glance at the history of language. (This latter so often makes some of the otherwise bewildering behavior of our crazy-lovely language acceptable and worth the struggle for mastery.)
5) Instruction in the use of the dictionary. This includes alphabetizing and pronunciation skills as well as the selection and what Dr. Gray so wisely called the "tuning in" of meanings.

Handwriting, oral and written expression, spelling as a means of written communication, reading, beyond the basic "mechanics" level, when it really becomes

the process of meaningful communication between writer and reader: all of these are essential to the child who is to be a functioning student. These essential elements of language training are integrated in the tutoring sessions as the child progresses.

When the trainee begins work with a child she has very basic materials, such as: a set of letter or phonics cards (for establishing sound-symbol relationships); word cards (for practicing the decoding process); some very simple, phonetically-oriented reading material. Other more sophisticated materials are available for use as needed.

Stated simply, the guidelines for all tutoring sessions are:

> Careful programming, so that success is assured, failure precluded. We are prepared to progress in very small units, or "ministeps", and to use more repetitive drill than would be usual for other children at the same intelligence level.
>
> A firm, cheerful operating atmosphere, honest and realistic, provides praise and encouragement. We seek constantly for opportunities to convey to each child respect for him as a person and our confidence that he can and will achieve.
>
> An inductive method is encouraged to make possible the heady joy of "discovering" a pattern, a generalization which will expand the area of competence in handling language.
>
> The English language is a fearful and yet a wonderful instrument of communication. Teachers should be in love with it themselves and try unremittingly to make work with it a satisfying experience for students with language disabilities.

Since our project was launched I have been constantly impressed with the attitudes of our volunteers -- their concern that they do well by their young charges; their faithfulness to their schedules and their tasks; their eagerness to keep searching and to learn more about children, these disabilities, our language, and about materials and techniques which will help them to be more effective in carrying out their assignments.

Bibliography available on request.